TAB 29

THE JOCKEYS' GUILD
MEMBER HEALTH PLAN

WHAT BENEFITS ARE INCLUDED?

- Medical, Dental, and Prescription Drugs
- $25,000 Life Insurance for enrolled Spouses
- Participation in a Retirement plan

WHO IS ELIGIBLE?

All Active Guild Members who have ridden at least **100 mounts** in the current or previous calendar year.

HOW MUCH DOES IT COST?

Plan	Monthly Premium		CA	DE
Single	$225	*Rates are guaranteed*	$80	$60
Member & 1 Dependent	$425	*for 6 months and*	$160	$120
Family	$550	*projected for 12 months*	$210	$160

HOW ARE THE PREMIUMS PAID?

- An additional **$7 per mount** is sent to the Guild.
- This $7 is deposited in your ***Personal Welfare Account.***
- Your monthly insurance premium is charge against your Personal Welfare Account.
- Unpaid premiums will be billed every two months.
- Excess in your Personal Welfare Account will be deposited into your retirement plan.

ARE ON-TRACK INJURIES COVERED?

- On-track injuries are not covered by the Guild's health plan.
- For non work-comp states, $100,000 of coverage provide by Guild-TRA agreement.
- Workman's compensation is provided in CA, CO, MD, NJ, and NY.
- The Guild can no longer afford the additional $1,000,000 in coverage.
- The Guild is now working to create a national workman's compensation program.

HOW TO ENROLL?

- Contact the Guild office for an enrollment package.
- Return the completed forms to the Guild along with 2 months premium.

The Jockeys' Guild
HEALTH PLAN ENROLLMENT INSTRUCTIONS

ENCLOSED IN THIS PACKET:

- Health Plan Enrollment Instructions
- Welcome to PHCS
- Member Health Plan
- 2002 Health Plan Benefits
- Health Plan Enrollment / Change
- Coordination of Benefits
- Benefits Premium Account Agreement
- Schedule of Benefits (8 pages)

Esos papeles esta en Espanol tambien

To be eligible, you must have ridden 100 mounts in the current or previous calendar year.

Participation in the Health Plan will required a physical examination by a medical doctor.

The physical examination will be waived during open enrollment.

There maybe exclusions based upon the physical examination.

COMPLETE AND SIGN THE FOLLOWING: (*Copies will be mailed to your permanent address*)

- ☐ Benefits Premium Account Agreement
- ☐ Health Benefits Enrollment
- ☐ Coordination of Benefits
- ☐ Payment for the first ***2 months of premiums*** payable to: **The Jockeys' Guild**

	Plan	*Premium*	*California*	*Delaware*
o	Single	$225 per month	$80 per month	$60 per month
o	Dependent	$425 per month	$160 per month	$120 per month
o	Family	$550 per month	$210 per month	$160 per month

Rates are guaranteed for 6 months and projected for 12 months

RETURN TO A GUILD MEMBER REPRESENTATIVE OR MAIL TO:

The Jockeys' Guild
PO Box 250
Lexington, KY 40588-0250

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE:

- Call the Guild Office at: ***866 GO JOCKS*** (866-465-6257)
- Contact a Member Representative or Delegate
- Visit us on the Internet at ***www.jockeysguild.com***

TAB 30

2 March 2004

VIA USPS FIRST CLASS MAIL and FACSIMILE (626) 821-1515

John K. Van de Kamp
President and General Counsel
Thoroughbred Owners of California
285 West Huntington Drive
Arcadia, California 91007

RE: HEALTH INSURANCE PREMIUMS

Dear John,

This letter is in response to your letter dated 19 February 2004 and open issue regarding more information on the health insurance premiums charged by the Guild for *The Jockeys' Guild Benefits Plan.*

The cost of the health insurance plan for all jockeys across the country, as determined by Marsh Risk and Insurance Services based on sound actuarial principles:

Single	$348.20
Dependent	696.34
Family	925.65

Subsidized premiums for jockeys outside of California, Delaware, and Massachusetts:

Single	$235.00
Dependent	445.00
Family	575.00

Note — less than five (5) percent increase over 2001-2 rates of $225, 425, and 550, respectively

These premiums are subsidized through Guild revenues, including but not limited to media rights revenue paid by tracks.

Subsidized premiums for jockeys in California:

Single	$80.00
Dependent	160.00
Family	210.00

Note — no increase of premiums over 2001-2002 rates

These premiums are subsidized through California un-cashed refunds.

The media rights and on-track injury insurance agreement with the Thoroughbred Racing Associations and the Jockeys' Guild stipulates that media rights be based on the following formula:

A Track..... $75/day + $7.57/mount
B Track..... $65/day + $4.96/mount
C Track..... $50/day + $3.63/mount

Historically, California racetracks have not paid the "per day" of the "per day plus per mount" fees. To the best of my knowledge, California tracks have always paid Guild mount fees (dues and insurance payments) and have offered the required catastrophic benefits.

The agreement, for California Health and Welfare unclaimed refund monies, mandates that the money reimbursed to the administrator be spent solely on California jockeys. The legislation or agreement does not specify how the Guild spends its revenue.

Please find enclosed another copy of the latest draft Agreement. A few minor changes were required, and the California Health and Welfare Committee are recommending a few. Furthermore, I am having a few parties review the requirements created from our last discussion, namely Mark Mathias from Marsh; our auditors, Piazza, Donnelly & Marlette; and our general counsel.

Paragraph 6 — Corrected proper accounting periods, and rather than specifying exact dates, simplified the text to encompass all dates since the agreement can survive the effective dates

Paragraph 10 — Retired jockey qualifications more strict (requested by the California Health and Welfare Committee); gives the permanently disabled qualifications more latitude if a jockey is injured outside of California but qualifies as a retired member (requested by the California Health and Welfare Committee)

Paragraph 15 — The BOARD's appropriation to the TRUST changed to April of each calendar year (requested by the California Health and Welfare Committee); since the appropriation belongs to the jockeys and rather than tracks earning interest, the TRUST can earn interest on the monies deposited netting more money for the jockeys.

Page 6 — Reflects the changes in qualification in paragraph ten.

Unless you have any immediate concerns, I will wait to hear from the aforementioned parties to discuss the Agreement further.

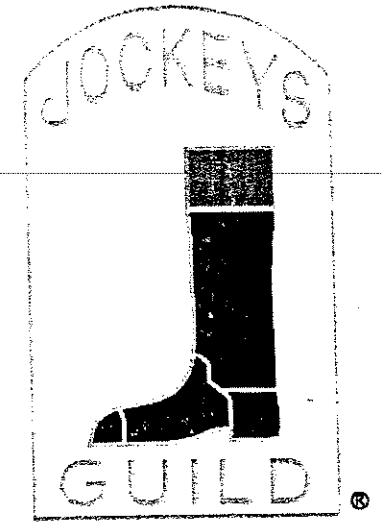
Very truly yours,

Stephen J. Rice
Controller & CFO

Enclosure

cc/enc: Barry Broad
John Reagan

TAB 31



THE JOCKEYS' GUILD

BENEFITS PLAN

RESTATED JANUARY 1, 2005

GENERAL INFORMATION

ERISA Plan Name: The Jockeys' Guild Benefits Plan

Type of Plan: Group medical, group dental, and group life insurance

Funding Medium: Medical and dental benefits are paid from the general assets of The Jockeys' Guild. For California riders, The Jockeys' Guild has established a trust known as The Jockeys' Guild Health and Welfare Trust.

Type of Administration: Contract administration for medical and dental coverage. Insurer administration for life insurance.

Name And Address Of The *Plan Sponsor*

The Jockeys' Guild
134 East Chestnut Ave
Monrovia, CA 91016
(866) 465-6257

Mailing Address

The Jockeys' Guild
P.O. BOX 150
Monrovia, CA 91017
(866) 465-6257

Name And Address Of The *Plan Administrator*

The Jockeys' Guild
134 East Chestnut Ave
Monrovia, CA 91016
(866) 465-6257

The Jockeys' Guild
P.O. BOX 150
Monrovia, CA 91017
(866) 465-6257

Name And Address Of The Designated Agent For Service Of Legal Process

Lloyd C. Ownbey, Jr.
Attorney at Law
180 Southlake Ave., Suite 540
Pasadena, CA 91101-2683

In addition, service of process may be made upon the *plan administrator* or a plan trustee.

Name and Addresses of Plan Trustees

Barry Hickey, Manager
Kathy LaPlant, Manager
Branch Banking and Trust Co.
223 West Nash St.
Wilson, NC 27894-2887

Name And Address Of The Third Party *Contract Administrator*

P5 e. Health Services, Inc.
P.O. Box 9554
Salt Lake City, UT 84109-0554

Internal Revenue Service And Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 13-1922798. The plan number is 501.

Plan Year

The *plan year* is the 12-month fiscal period for The Jockeys' Guild beginning January 1 and ending December 31.

Sources of Contributions to the Plan

The Thoroughbred Racing Association makes contributions to the plan pursuant to a collective bargained agreement. The State of California, the State of Delaware, and the State of Massachusetts make contributions pursuant to state statutes. Participants who participate in the plan or one or more components of the plan are required to make contributions to the plan for coverage. The amount of the participants' contributions is based on actuarial principles. The contributions will be applied to pay the cost of administrative expenses and health and welfare benefits under the plan.

Collective Bargaining

The plan is maintained pursuant to a collective bargained agreement. A copy of the agreement may be obtained by participants upon request to the *plan administrator*.

INTRODUCTION

The Jockeys' Guild has prepared this document to help you understand your benefits. Please read it carefully. Your benefits are affected by certain limitations and conditions which require you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your *health care provider* recommends them. **Injuries acquired at/on racetracks or at/on racetrack properties (including training facilities) will not be covered.**

This document is written in simple, easy-to-understand language. Technical terms are printed in *italics* and defined in the Definitions section.

As used in this document, the word *year* refers to the *benefit year* which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *benefit year*. The word *lifetime* as used in this document refers to the period of time you or your eligible dependents participate in this plan.

The Jockeys' Guild reserves the right to amend, modify or terminate the plan in any manner, at any time, which may result in the termination or modification of your coverage. Expenses incurred prior to the plan termination will be paid as provided under the terms of the plan prior to its termination.

Benefits described in this document are effective January 1, 2005.

ELIGIBILITY AND PARTICIPATION

Who Is Eligible

You are eligible to participate in this plan if you are an *active member* (includes managers and full-time employees) enrollee of The Jockeys' Guild Those Members and their families enrolling during the *plan year*, **must have had at least 100 mounts from flat racing in the current or previous calendar year**. Eligibility for *Medicaid* or the receipt of *Medicaid* benefits will not be taken into account in determining eligibility. If you are eligible to participate in The Jockeys' Guild – California Riders Benefit Plan, you are not eligible to participate in this plan.

Your eligible dependents may also participate. Eligible dependents include: your lawful spouse as defined by applicable state law; natural children; stepchildren; children who, before reaching the age of 18, are either adopted by you or placed in your home for adoption; and children for whom you are legal guardian. A dependent child must be unmarried and rely on you for primary support and maintenance. Dependent children remain eligible until age 19, or until age 23 if enrolled as a full-time student in a university, college, vocational school, secondary school or institution for the training of nurses. Accredited documentation must be submitted to The Jockeys' Guild or P5 e. Health Services, Inc.

It is the intent of the plan to provide a 90-day extension for students who experience a break in full-time student status, who have previously met their school's definition of full-time student status and intend to enroll in the next regularly scheduled semester/quarter. For example, coverage for full-time students is extended for those not enrolled in summer school or pre-enrolled to continue their full-time status in the fall semester/quarter. This, in effect, gives a full-time student 90 days in which to enroll in the fall semester/quarter after completion of the spring semester/quarter. However, if a student fails to register or participate in fall classes or the next regularly scheduled semester/quarter, the student would be considered ineligible for participation as a dependent under this plan the end of the month following the 90-day extension. Coverage would then be available through COBRA. Coverage for graduating students will terminate at the end of the month in which graduation occurs unless the individual re-enrolls as a full-time student in an additional course of study.

If a dependent child is enrolled in the plan and is *physically or mentally handicapped* on the date coverage would otherwise end, the child's eligibility will be extended for as long as you are covered by this plan, the handicap continues and the child continues to qualify for coverage in all aspects other than age. The plan may require you at any time to obtain a *physician's* statement certifying the *physical or mental handicap*.

You may not participate in this plan as both an enrollee and a dependent.

If The Jockeys' Guild determines that your separated or divorced spouse or any state child support or *Medicaid* agency has obtained a legal qualified medical child support order (QMCSO), through a court order or an administrative process established under state law, and your current plan offers dependent coverage, you will be required to provide coverage for any child(ren) named in the QMCSO. If a QMCSO requires that you provide health coverage for your child(ren) and you do not enroll the child(ren), The Jockeys' Guild must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency or *Medicaid* agency and withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence to The Jockeys' Guild that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). The *plan administrator* has discretion to adopt procedures to determine if a child support order satisfies the requirements of a QMCSO. Participants and beneficiaries can obtain a copy of the procedures governing QMCSO determinations from the *plan administrator* without charge.

Plan Changes May Occur

The Jockeys' Guild shares the cost of providing benefits for you and your dependents. From time to time, The Jockeys' Guild may adjust the amount of contributions required for coverage. In addition, the deductibles and co-payments may also change periodically. You will be notified of any changes in the cost of plan coverage before they take effect.

When Coverage Begins

When the enrollment requirements are met, coverage for you and your dependents begins on the first day of the month that you become eligible, which includes Jockeys' Guild and P5 Health Services, Inc. receiving complete information on forms required, as well as the first two consecutive months premium payments.

If you desire dependent coverage, you must enroll your eligible dependents at this time. If you do not have any eligible dependents at the time of initial enrollment, but acquire eligible dependents at a later date, you must enroll the dependent(s) within 30 days of the date you acquire them. To enroll, you must complete and return any enrollment forms required or provided by The Jockeys' Guild within the applicable time period. You may be required to obtain and provide The Jockeys' Guild with a Social Security number for each covered dependent.

Your newborn child is automatically covered at birth for 30 days. For coverage to continue beyond 30 days, you must notify your The Jockeys' Guild of the birth, properly enroll your child, and pay any required contribution. If enrollment and contribution are not made, coverage will terminate at the end of 30 days following your child's birth. Your claim for maternity expenses is not considered as notification to The Jockeys' Guild or enrollment of your child for coverage to continue beyond 30 days.

You are allowed to change your enrollment elections during a *benefit year* if you have a change in status. If you have a qualifying change in your status, you may change your enrollment decision within 30 days of the change in status by notifying The Jockeys' Guild and completing and returning any required forms. Your change in enrollment election must be consistent with your change in status. In other words, you may only change your election if the change in status causes you, your spouse or your child to gain or lose eligibility for coverage under this or another plan, and the election change must correspond with the effect on coverage.

MEDICAL EXPENSES NOT COVERED

The plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give you a description of expenses for services and supplies not covered by the plan.

1. Expenses exceeding the *usual and customary charge* for the geographic area in which services are rendered.

2. Services rendered by anyone other than a covered *health care provider*.

3. Treatment not prescribed or recommended by a *health care provider*.

4. Services, supplies or treatment not *medically necessary*.

5. Services or supplies for which there is no legal obligation to pay, or expenses which would not be made, except for the availability of benefits under this plan.

6. *Experimental/investigational* equipment, services or supplies.

7. Complications arising from any non-covered *surgery* or treatment, except as required by law.

8. Services furnished by or for the United States Government or any other government, unless payment is legally required.

9. Any condition, disability or expense sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of an illegal or criminal act.

10. Any condition, disability or expense sustained as a result of: duty as a member of the armed forces of any state or country; engaging in a war or act of war, whether declared or undeclared; participation in a civil revolution or riot; or an intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime.

11. **Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under a workers' compensation act or similar legislation, including on-track injuries.**

12. Educational, vocational or training services and supplies, except as specified in Covered Medical Expenses.

13. Expenses for preparing or copying medical reports, itemized bills or claim forms.

14. Mailing and/or shipping and handling expenses.

15. Sales tax.

16. Expenses for broken appointments or telephone calls or telephone consultations.

17. Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.

18. Travel expenses of a *physician* or a covered person.

19. *Maintenance care.*

20. Sanitarium, rest or *custodial care.*

21. Expenses eligible for consideration under any other plan of the *plan sponsor.*

22. Treatment or services rendered outside the United States of America or its territories, except for an accidental *injury* or a *medical emergency.*

23. Personal comfort or service items while confined in a *hospital*, such as, but not limited to, radio, television, telephone and guest meals.

24. *Hospital* confinement expenses for dental services.

25. Dental services received after an accidental *injury* to teeth.

26. *Oral surgery.* (Benefits are available under the Dental Benefits section of this plan.)

27. *Cosmetic surgery.*

28. Removal of breast or other prosthetic implants.

29. Surgical treatment of *morbid obesity.*

30. Kerato-refractive eye *surgery* (*surgery* to improve nearsightedness, farsightedness and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy and keratomileusis *surgery*).

31. Surgical reproductive sterilization.

32. Reversal of any reproductive sterilization procedure.

33. Surgical impregnation procedures.

34. Surgical treatment for the correction of infertility.

35. Surgical treatment of temporomandibular joint dysfunction (TMJ).

36. Orthognathic *surgery.*

37. Sex change *surgery.*

38. Penile prosthetic implants.

39. Expenses related to insertion or maintenance of an artificial heart.

40. Expenses for education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.

41. Massage therapy or rolfing.

42. Occupational therapy, including supplies.

43. Acupuncture.

44. Orthoptics, vision therapy or supplies, unless such treatment is due to a covered *illness* or accidental *injury*.

45. Hearing examinations, hearing aids or related supplies, unless loss of hearing is due to a covered *illness* or accidental *injury*.

46. Adoption expenses.

47. Surrogate expenses.

48. Amniocentesis, including any testing performed in connection with the procedure.

49. Biofeedback.

50. Treatment of or related to sleep disorders.

51. Private-duty nursing services.

52. Non-surgical treatment of temporomandibular joint dysfunction (TMJ).

53. Non-surgical treatment of *morbid obesity*.

54. Treatment, instructions, activities or drugs (including diet programs) for weight reduction or control.

55. Non-surgical treatment for the correction of infertility.

56. Expenses incurred for non-surgical treatment of the feet, including treatment of corns, calluses and toenails, or other routine foot care, except as specified in Covered Medical Expenses.

57. Hypnosis.

58. Prescription drugs and medicines, including contraceptives, insulin and insulin syringes. Benefits are provided by P5 Rx/Express Scripts.

59. Infertility drugs, vitamins and nutritional supplements (including prenatal vitamins), whether or not a *physician's* prescription is required.

60. Drugs, medicines or supplies that do not require a *physician's* prescription.

61. B-12 injections.

62. Allergy injections.

63. Artificial limbs and eyes.

64. Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.

65. Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.

Order Of Payment When Coordinating With Other Group Health Plans

Any group health plan which does not contain a coordination of benefits provision will be considered primary.

When all plans covering you and/or your dependents contain a coordination of benefits provision, the first of the following rules that describes which plan will pay benefits before another plan is the rule to follow:

1. The plan covering an individual other than as a dependent (for example, as an active employee or retiree) will be primary to a plan covering the same individual as a dependent. However, if the individual is covered by two group health plans and *Medicare*, and under federal law *Medicare* is:

   - secondary to the plan covering the individual as a dependent; and
   - primary to the plan covering the individual as other than a dependent (for example, a retiree);

   then the order of payment is reversed so the plan covering the individual as an employee or retiree is secondary and the other plan is primary.

2. If a dependent child is covered under more than one plan, the primary plan is the plan of the parent whose birthday (month and day) is earlier in the calendar year if:

   - the parents are married; or
   - the parents are not separated (regardless of whether they ever have been married); or
   - a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

   If both parents have the same birthday (month and day), the plan that has covered either of the parents longer is primary.

   If the specific terms of a court decree state that one of the parents is responsible for the child's health care coverage or expenses and the plan of that parent has knowledge of the decree, that plan is primary. If the parent designated by the decree has no coverage for the child but that parent's spouse does, the spouse's plan is primary.

   If the parents are not married, are separated (regardless of whether they were ever married), or are divorced and there is no court decree allocating responsibility for the child's health care coverage or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

   - the plan of the custodial parent;
   - the plan of the spouse of the custodial parent;
   - the plan of the noncustodial parent; then
   - the plan of the spouse of the noncustodial parent.

3. The plan that covers an individual as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. However, the order of benefit determination for an individual covered both as a retiree and as a dependent of that individual's spouse will be determined under section No. 1 above.

4. The plan covering the individual as an employee or retiree (or as that individual's dependent) will be primary to the plan providing continuation coverage under federal (COBRA) or state law.

5. The plan that has covered the individual for the longer period of time will be considered primary.

6. If none of the above rules determines the primary plan, the allowable expenses will be shared equally between the plans.

Right To Make Payments To Other Organizations

Whenever payments which should have been made by this plan have been made by any other plan(s), this plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this plan and, to the extent of such payments, the plan will be fully released from any liability regarding the person for whom payment was made.

OTHER IMPORTANT PLAN PROVISIONS

Assignment Of Benefits

All benefits payable by the plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim form. Payments made in accordance with an assignment are made in good faith and release the plan's obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state *Medicaid* plan.

Special Election For Members And Spouses Age 65 And Over

If you remain actively employed after reaching age 65, you or your spouse may choose to remain covered under this plan without reduction for *Medicare* benefits or designate *Medicare* as the primary payor of benefits. If you choose to remain covered under this plan, this plan will be the primary payor of benefits and *Medicare* will be secondary. If you choose *Medicare* as primary, coverage under this plan will end. If you do not specifically choose one of the options, this plan will continue to be primary.

If you are under age 65 and your spouse is over age 65, he or she can make his or her own choice.

Reimbursement To The Plan

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict or otherwise, for an *illness* or *injury*. In that case, you or your dependent (or the legal representatives, estate or heirs of either you or your dependent), must promptly reimburse the plan for any benefits it paid relating to that *illness* or *injury*, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent have been made whole). If the plan has not yet paid benefits relating to that *illness* or *injury*, the plan may reduce or deny future benefits on the basis of the compensation received by you or your dependent.

Benefits relating to such *illness* or *injury* will not be payable by the *plan* until you sign and return a statement, provided by the *plan,* acknowledging your obligation to reimburse the *plan* under this provision. (That obligation will arise upon the payment of any plan benefits relating to the *illness* or *injury,* whether or not you sign such a statement).

You or your dependent must cooperate with the plan and its agents, and must sign and deliver such documents as the plan or its agents reasonably request to protect the plan's right of reimbursement. You or your dependent must also provide any relevant information, and take such actions as the plan or its agents reasonably request to assist the plan in making a full recovery of the reasonable value of the benefits provided. You or your dependent must not take any action that prejudices the plan's right of reimbursement.

In order to secure the rights of the plan under this section, you or your dependent hereby: (1) grant to the plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by you or your dependent; and (2) assign to the plan any benefits you or your dependent may have under any automobile policy or other coverage, to the extent of the plan's claim for reimbursement.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the *plan administrator*, in the exercise of its sole discretion.

Subrogation

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent for your or your dependent's *illness* or *injury* and the plan has paid benefits related to that *illness* or *injury*.

The plan is subrogated to all of the rights of you or your dependent against any party liable for your or your dependent's *illness* or *injury* to the extent of the reasonable value of the benefits provided to you or your dependent under the plan. The plan may assert this right independently of you or your dependent.

You or your dependent are obligated to cooperate with the plan and its agents in order to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with any relevant information requested by them, signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation claim, and obtaining the consent of the plan or its agents before releasing any party from liability for payment of medical expenses.

If you or your dependent enter into litigation or settlement negotiations regarding the obligations of other parties, you or your dependent must not prejudice, in any way, the subrogation rights of the plan under this section.

The costs of legal representation of the plan in matters related to subrogation will be borne solely by the plan. The costs of legal representation of you or your dependent must be borne solely by you or your dependent.

Additional Plan Provisions Governing Reimbursement And Subrogation

The benefits advanced hereunder as a result of any injuries which give rise to a claim by any participant, beneficiary or any other covered person, hereinafter individually and collectively "participant", against a third party tortfeasor or against any person or entity as the result of the actions of a third party are excluded from coverage under this plan. This plan also does not provide benefits to the extent that there is other coverage under non-group medical payments including auto or medical expense type coverage to the extent of that coverage. However, this plan will advance benefits, otherwise payable under this plan, to or on behalf of said participant only on the following terms and conditions:

1. In the event that benefits are advanced under this plan, the plan shall be subrogated to all of the participant's (the term participant includes any person receiving benefits hereunder including all dependents) rights of recovery against any person or organization to the extent of the benefits provided. The participant shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The participant shall do nothing after loss to prejudice such rights. The participant hereby agrees to cooperate with the plan and/or any representatives of the plan in completing such forms and in giving such information surrounding any accident as the plan or its representatives deem necessary to fully investigate the incident.

2. The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

3. The plan, by advancing benefits hereunder, is hereby granted a right to impress an equitable lien or constructive trust on the proceeds of any settlement, judgment or other payment intended for, payable to, or received by the participant or his/her representatives, and the participant hereby consents to said equitable lien and agrees to take whatever steps are necessary to help the company secure said equitable lien. The participant agrees that said equitable lien shall constitute a charge upon the proceeds of any recovery and the plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the plan, the participant and his/her representatives agree: (a) to hold the proceeds of any settlement in trust for the benefit of the plan to the extent of 100% of all benefits paid on behalf of the participant and (b) that any settlement, judgment or other recovery proceeds held by another person or entity on the participant's behalf are being held for the benefit of the plan under these provisions.

4. By accepting benefits hereunder, the participant hereby grants the plan the right to impress an equitable lien or constructive trust and assigns to the company an amount equal to the benefits paid against any recovery made by or on behalf of the participant. This assignment is binding upon any attorney who represents the participant whether or not an agent of the participant and on any insurance company or other financially responsible party against whom a participant may have a claim provided said attorney, insurance carriers or others have been notified by the company or its agents.

5. The subrogation and reimbursements rights, assignments, equitable liens, and constructive trusts apply to any recoveries made by the participant as a result of the injuries sustained, including but not limited to the following:

   a. Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third part tortfeasor, or any other payments on behalf of the third party tortfeasor.

   b. Any payments, settlements, judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a participant or other person.

   c. Any other payments from any source designed or intended to compensate a participant for injuries sustained as the result of negligence or alleged negligence of a third party.

   d. Any workers' compensation award or settlement.

   e. Any recovery made pursuant to no-fault insurance.

   f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

6. No adult participant hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult participant without the prior express written consent of the plan. The plan's rights to recover (whether by subrogation or reimbursement) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

7. No participant shall make any settlement which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the plan.

8. The plan's right of recovery shall be a prior claim against any proceeds recovered by the participant, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Full Compensation Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

9. No participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder. Specifically, no court costs nor attorneys fees may be deducted from the plan's recovery without the prior expressed written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine" or "Common Fund Doctrine," or "Attorney's Fund Doctrine".

10. The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any participant, whether under comparative negligence or otherwise.

11. The benefits under this plan are secondary to any coverage under no-fault or similar insurance.

12. In the event that a participant shall fail or refuse to honor his/her obligations hereunder, then the plan shall be entitled to recover the costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses.

13. Any reference to state law in any other provision of this policy shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under this plan, the participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Recovery Of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this plan, the plan has the right to recover these excess payments from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the plan will exercise all available legal rights, including its right to withhold payment on future benefits, until the overpayment is recovered.

Right To Receive And Release Necessary Information

The plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information, including your medical information, for treatment, payment, or health care operations. This plan may condition eligibility for benefits and enrollment in this plan on the individual's authorization for use of disclosure of protected health information for purposes of eligibility or enrollment determinations relating to the individual or for the plan's underwriting or risk-rating determinations.

Alternate Payee Provision

Under normal conditions, benefits are payable to the provider of services or supplies, unless evidence of previous payment is submitted with the claim form. If conditions exist under which a valid release or assignment cannot be obtained, the plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The plan must make payments to your separated/divorced spouse, state child support agencies or *Medicaid* agencies if required by a qualified medical child support order (QMCSO) or state *Medicaid* law.

The plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the plan.

Any payment made by the plan in accordance with this provision will fully release the plan of its liability to you.

Reliance On Documents And Information

Information required by the *plan administrator* may be provided in any form or document that the *plan administrator* considers acceptable and reliable. The *plan administrator* relies on the information provided by you and others when evaluating coverage and benefits under the plan. All such information, therefore, must be accurate, truthful and complete. The *plan administrator* is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to the *plan administrator*. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the plan.

No Waiver

The failure of the *plan administrator* to enforce strictly any term or provision of this plan will not be construed as a waiver of such term or provision. The *plan administrator* reserves the right to enforce strictly any term or provision of this plan at any time.

Physician/Patient Relationship

This plan is not intended to disturb the *physician*/patient relationship. *Physicians* and other *health care providers* are not agents or delegates of the *plan sponsor*, *plan administrator* or the third party *contract administrator*. Nothing contained in this plan will require you or your dependent to commence or continue medical treatment by a particular provider. Further, nothing in this plan will limit or otherwise restrict a *physician's* judgment with respect to the *physician's* ultimate responsibility for patient care in the provision of medical services to you or your dependent.

Plan Is Not A Contract Of Employment

Nothing contained in this plan will be construed as a contract or condition of employment between the *plan sponsor* and any Member. All Members are subject to discharge to the same extent as if this plan had never been adopted.

Right To Amend Or Terminate Plan

The *plan sponsor* reserves the right to amend, modify or terminate the plan in any manner, for any reason, at any time.

STATEMENT OF ERISA RIGHTS

As a participant in The Jockeys' Guild Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

2. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependent if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group heath plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including an employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to this decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

SIGNATURE PAGE

The effective date of The Jockeys' Guild Benefits Plan is January 1, 2005.

It is agreed by The Jockeys' Guild that the provisions of this document are correct and will be the basis for the administration of The Jockeys' Guild Benefits Plan.

Dated this 19th day of January, 2005

BY _____

TITLE Benefits Adm

BY _____

TITLE _____

SIGNATURE PAGE

The effective date of The Jockeys' Guild Benefits Plan is January 1, 2005.

It is agreed by The Jockeys' Guild that the provisions of this document are correct and will be the basis for the administration of The Jockeys' Guild Benefits Plan.

Dated this _____ day of _____, _____

BY

_____

TITLE

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BY

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TITLE

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